PACIFIC PAIN
care consultants

1561 E ONTARIO AVE. SUITE 103A. CORONA, CA 92881
T– 951 735 PAIN (7246). F– 951 273 1555
WWW.PACIFICPAINCARE.COM

Comprehensive Pain Questionnaire

Last Name _____ First _____ Middle Initial _____

Date of Birth _____ Age _____

Weight _____ Height _____

Chief Complaint

ONSET OF PAIN

How did your current pain start?

- ☐ Injury at work
- ☐ Treatment caused (e.g., radiation, surgery, etc.)
- ☐ Injury, not at work
- ☐ Motor vehicle accident
- ☐ Illness, non-injury
- ☐ Undetermined
- ☐ Other_____

_____

_____

DURATION

How long have you had your current pain problem? _____ Years _____ Months

PRIOR CONSUATIONS

Which physicians have you seen for your current condition?

- ☐ Primary Care Physician_____
- ☐ Neurologist _____
- ☐ Orthopedic surgeon_____
- ☐ Neurosurgeon_____
- ☐ Physiatrist_____
- ☐ Other_____

DIAGNOSTIC STUDIES

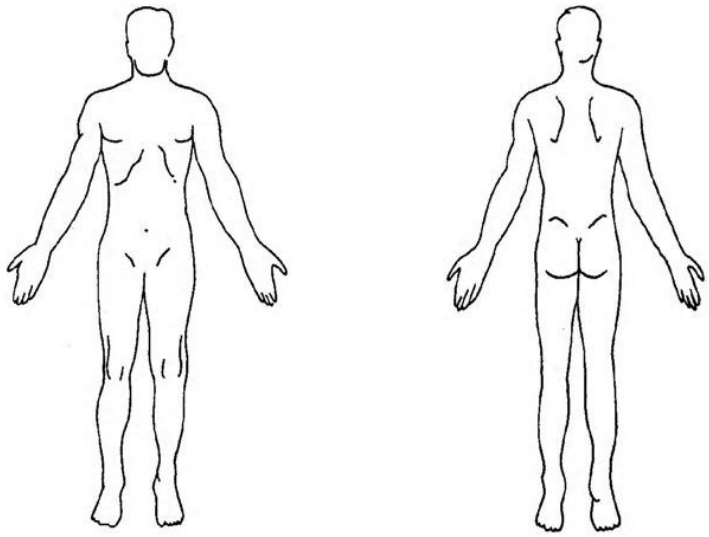
What diagnostic studies have you had?

- ☐ MRI:
  - a. Back — Date:_____
  - b. Neck — Date:_____
- ☐ CT scan:
  - a. Back — Date:_____
  - b. Neck — Date:_____
- ☐ EMG — Date:_____
- ☐ X-rays — Date:_____
- ☐ Other_____ — Date:_____

PAIN LOCATION

Please describe the location(s) of you pain:

_____



Front ***Back***

Please mark the location(s) of your pain on the diagrams above. If whole areas are painful, please shade in the painful area.

RATE YOUR PAIN

(0-10 scale where 0 is no pain and a 10 is the worst possible pain)

I would rate my pain today a _____/10

I would rate my worst pain a _____/10.

I would rate my pain when under control as a _____/10.

I could accept or live with a level of pain at a _____/10.

PAIN QUALITY

How would you describe the pain?

☐ Burning ☐ Sharp ☐ Cutting ☐ Throbbing
☐ Cramping ☐ Numbness ☐ Dull
☐ Aching ☐ Pressure ☐ Soreness
☐ Pins and needles ☐ Shooting ☐ Other_____

In general, during the past month when has your pain been (please check one)?

☐ Worsening ☐ Improving ☐ Unchanged

TIMING OF PAIN

How often do you have your pain? (Please check one)

☐ Constantly (100% of the time)
☐ Nearly constantly (60% to 95% of the time)
☐ Intermittently (30% to 60% of the time)
☐ Occasionally (less than 30% of the time)

ACTIVITIES AND YOUR PAIN

During the past month, check the activities that you avoided because of pain:

☐ Going to work ☐ Performing household chores
☐ Doing yard work or shopping ☐ Socializing with friends
☐ Participating in recreation ☐ Having sexual relations
☐ Physically exercising

Does your pain cause any of the following?

☐ Loss of bowl control ☐ Loss of bladder control ☐ Loss of sleep

How many blocks can you walk before having to stop secondarily to pain?

☐ Less than a block _____blocks

How many minutes or hours can you sit before having to get up and move about?

_____Hours _____Minutes

How many minutes or hours can you stand before you have to sit down?

_____Hours _____Minutes

How often during the day do you lie down because of pain?

☐ Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Constantly

RELIEVING AND AGGREVATING FACTORS

How do the following affect your pain? (Please check one for each item)

	Decrease	No Change	Increase
Lying down	☐	☐	☐
Standing	☐	☐	☐
Sitting	☐	☐	☐
Walking	☐	☐	☐
Exercise (if applicable)	☐	☐	☐
Medications	☐	☐	☐
Relaxation	☐	☐	☐
Thinking about something else	☐	☐	☐
Coughing/Sneezing	☐	☐	☐
Urination	☐	☐	☐
Bowel movements	☐	☐	☐

PAIN TREATMENTS

Please check all of the treatments you have tried for your pain and then complete the appropriate column at the right to the best of your ability.

	Treatment	Date (approximate)	No Relief	Moderate Relief	Excellent Relief
☐	Hospital bed rest		☐	☐	☐
☐	Traction		☐	☐	☐
☐	Surgery		☐	☐	☐
☐	Hypnosis		☐	☐	☐
☐	Acupuncture		☐	☐	☐
☐	Nerve block or injections		☐	☐	☐
☐	TENS		☐	☐	☐
☐	Physical therapy		☐	☐	☐
☐	Exercise		☐	☐	☐
☐	Biofeedback		☐	☐	☐
☐	Psychotherapy		☐	☐	☐
☐	Chiropractic		☐	☐	☐
☐	Other		☐	☐	☐

PRIOR MEDICAL HISTORY

Have you had any of the following health problems? (Please check all that apply)

☐ High blood pressure ☐ Diabetes or high blood sugar ☐ Kidney disease
☐ Angina or chest pain ☐ Heart attack ☐ Liver disease
☐ Asthma or wheezing ☐ Chronic cough ☐ Arthritis
☐ (TIA) or stroke ☐ Seizure or epilepsy ☐ Bleeding problem
☐ Cancer; please specify what type_____
☐ Other; please specify _____

_____

_____

PAST SURGICAL HISTORY

Date (approximate)	***Hospital***	***Type of Operation***

FAMILY HISTORY

Mother

Father

Siblings

Other

REVIEW OF SYSTEMS

Constitutional
- ☐ Weight change
- ☐ Loss of appetite
- ☐ Fatigue
- ☐ Insomnia
- ☐ Fever

Cardiovascular
- ☐ Heart trouble
- ☐ Chest pain
- ☐ Heart murmur
- ☐ Palpitations
- ☐ Varicose veins
- ☐ Swelling of the feet or ankles

Gastrointestinal
- ☐ Nausea
- ☐ Diarrhea
- ☐ Constipation
- ☐ Abdominal pain
- ☐ Blood in the stool

Neurological
- ☐ Frequent headaches
- ☐ Light headed or dizzy
- ☐ Convulsions or seizures
- ☐ Numbness or tingling
- ☐ Tremors
- ☐ Paralysis
- ☐ Head injury
- ☐ Memory loss
- ☐ Fainting
- ☐ Poor balance

Eyes
- ☐ Eye disease
- ☐ Glasses or contacts
- ☐ Blurred or double vision
- ☐ Vision loss

Genitourinary
- ☐ Frequent urination
- ☐ Urgency of urination
- ☐ Painful urination
- ☐ Incontinence
- ☐ Sexual difficulty
- ☐ Kidney stones

Respiratory
- ☐ Shortness of breath
- ☐ Chronic cough
- ☐ Wheezing

Ears/Nose/Mouth/Throat
- ☐ Hearing loss
- ☐ Ringing in the ears
- ☐ Sinus problems
- ☐ Nose bleeds
- ☐ Mouth sores
- ☐ Swollen glands in the neck

Hematological
- ☐ Bleeding tendency
- ☐ Anemia
- ☐ Recurrent infections

Psychiatric
- ☐ Nervousness
- ☐ Depression
- ☐ Hallucination

Musculoskeletal
- ☐ Joint pain
- ☐ Joint swelling
- ☐ Weakness of muscles or joints
- ☐ Muscle pain or cramps
- ☐ Back pain
- ☐ Difficulty walking

Endocrine
- ☐ Excessive thirst
- ☐ Heat or cold intolerance
- ☐ Glandular or hormone problems

Skin
- ☐ Rash or itching
- ☐ Change in skin color
- ☐ Change in hair or nails

MEDICATIONS

Indicate the prescription medications you currently taking by ☐ checking the box. Please tell us the dosage (if known) and number of pills you take (on average) of this medication. Write this in the space next to the name of the medication.

If you can remember, draw a line through the name of any medications that you have tried in the past but are no longer taking.

- ☐ Actiq
- ☐ Adapin (Doxepin)
- ☐ Amrix
- ☐ Anaprox (Naproxen)
- ☐ Anexsia (Hydrocodone)
- ☐ Ativan
- ☐ Avinza
- ☐ Axert
- ☐ Baclofen (Lioresal)
- ☐ Buprenorphine
- ☐ BuSpar
- ☐ Celebrex
- ☐ Codeine
- ☐ Cymbalta
- ☐ Darvocet
- ☐ Darvon
- ☐ Desyrel (Trazodone)
- ☐ Dilaudid
- ☐ Elavil (Amitriptyline)
- ☐ Empirin with codeine
- ☐ Endocet
- ☐ Feldene
- ☐ Fentanyl
- ☐ Fiorinal
- ☐ Fiorinal with codeine
- ☐ Flexeril
- ☐ Frova
- ☐ Halcion
- ☐ Ibuprofen (Motrin) (Advil)
- ☐ Imitrex (Sumatriptan)
- ☐ Indocin
- ☐ Kadian
- ☐ Klonopin (Clonazepam)
- ☐ Lexapro
- ☐ Lidoderm 5%
- ☐ Limbrel
- ☐ Lioresal
- ☐ Lortab
- ☐ Lyrica
- ☐ (Hydrocodone)
- ☐ Methadone
- ☐ Mobic
- ☐ Morphine
- ☐ MS Contin
- ☐ Naprelan
- ☐ Naprosyn
- ☐ Norco (Hydrocodone)
- ☐ Norflex
- ☐ Norpramin (Desipramine)
- ☐ Opana (IR/ER)
- ☐ Oxycodone
- ☐ Oxycontin
- ☐ Pamelor (Nortriptyline)
- ☐ Percocet (Oxycodone)
- ☐ Percodan (Oxycodone)
- ☐ Provigil
- ☐ Prozac
- ☐ Restoril
- ☐ Ritalin
- ☐ Robaxin
- ☐ Roxicodone
- ☐ Sinequan (Doxepin)
- ☐ Skelaxin
- ☐ Soma
- ☐ Tegretol
- ☐ Tofranil (Imipramine
- ☐ Topamax
- ☐ Toradol
- ☐ Tylenol with codeine
- ☐ Tylox
- ☐ Valium
- ☐ Vicodin
- ☐ Ultracet
- ☐ Ultram (Tramadol)
- ☐ Ultram ER
- ☐ Xanax (Alprazolam)
- ☐ Zanaflex (Tizanidine)
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

Do you take opioid medications? (circle) **YES** **NO**

As a result of taking opioid medications I can do the following-

_____

_____

_____

ALLERGIES ☐ I am allergic to dye (Contrast)

Please indicate the names of any medications that you are allergic to in the space below

---

EDUCATION

Your highest educational level achieved:

☐ Graduate or professional training (obtained degree)
☐ College graduate (obtained degree)
☐ Partial college training
☐ High school graduate
☐ GED or trade-technical school graduate
☐ Partial high school (10th grade through partial 12th)
☐ Partial junior high school (7th grade through 9th grade)
☐ Elementary school (6th grade or less)

EMPLOYMENT

Your current or former occupation:

☐ Skilled trade or clerical (e.g., carpenter, electrician, truck driver, secretary)
☐ Semi-skilled or unskilled (e.g., dishwasher, porter, assembler)
☐ Business executive or managerial
☐ Professional (e.g., lawyer, teacher, nurse, physician, psychologist)
☐ Homemaker
☐ Other

Current employment status (please check all that apply):

☐ Employed full-time
☐ Employed part-time
☐ Unemployed
☐ Homemaker
☐ Retired
☐ Student
☐ Unemployed because of pain
☐ Part-time because of pain

If you are currently unemployed, indicate how long you have been off work: (If employed, do not answer)

☐ 1 - 3 weeks
☐ 1 - 3 months
☐ 4 - 7 months
☐ 8 - 11 months
☐ 12 - 18 months
☐ 19 - 24 months
☐ 25 or more months

LEGAL ISSUES

Please indicate any of the following claims you have filed related to your pain problem

☐ Workers' compensation
☐ Personal injury/liability (unrelated to work)
☐ Social Security Disability Insurance (SSDI)
☐ Other insurance
☐ None

ATTORNEY'S NAME & CONTACT INFORMATION

_____

SOCIAL

Alcohol use ☐ Yes ☐ No _____/Week?

Tobacco use ☐ Yes ☐ No _____/packs per day

Recreational drug use ☐ Yes ☐ No _____

Marital status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widow

Living arrangements ☐ Living alone ☐ Living with friends ☐ Living with children ☐ Living with spouse/partner ☐ Living with other

PSYCHOLOGICAL TREATMENT

Have you ever had psychiatric, psychological, or social work evaluations or treatments for any problem, including your current pain? ☐ Yes ☐ No
If yes, when?

Have you ever considered suicide? ☐ Yes ☐ No
If yes, when?

SUBSTANCE ABUSE

Do you have a history of alcoholism? ☐ Yes ☐ No
Heroin abuse? ☐ Yes ☐ No
Cocaine abuse? ☐ Yes ☐ No
Have you ever been in a detoxification program for drug abuse? ☐ Yes ☐ No
Alcoholics Anonymous? ☐ Yes ☐ No